FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Anti-obesity Drugs Completion Instructions, F-00163A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Providers may call the Drug Authorization and Policy Override Center at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number	3. Date of Birth — Member

SECTION II — PROVIDER INFORMATION

4. Name — Prescriber	5. National Provider Identifier (NPI) — Prescriber

6. Address — Prescriber (Street, City, State, ZIP+4 Code)

7. Telephone Number — Prescriber

8. Name — Billing Provider	9. NPI — Billing Provider

SECTION III — PRESCRIPTION INFORMATION

10. Drug Name	11. Drug Strength
12. Date Prescription Written	13. Directions for Use

14. Refills

SECTION IV — CLINICAL INFORMATION

15. Diagnosis Code and Description

16. Height — Member (Inches)	17. Weight — Member (Pounds)
18. Date Member's Weight Was Measured	19. Body Mass Index (BMI) — Member (lb / in^2)
20. Goal Weight — Member (Pounds)	BMI = $\frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$

Continued

DT-PA085-085

For an initial drug request, the prescriber should complete Sections IV A and IV B. For a renewal drug request, the prescriber should complete Section IV A.

SECTION IV A — INITIAL AND RENEWAL COVERAGE REQUIREMENTS

21. Is the member pregnant or nursing?	❑ Yes	❑ No
22. Does the member have a history of an eating disorder (e.g., anorexia, bulimia)?	❑ Yes	❑ No
23. Has the member had bariatric surgery?	❑ Yes	❑ No
24. Has the prescriber evaluated and determined that the member does not have any medical or medication contraindications to treatment with the anti-obesity drug being requested?	❑ Yes	❑ No
25. Does the member have a medical history of substance abuse or misuse?	❑ Yes	❑ No

SECTION IV B — INITIAL COVERAGE REQUIREMENTS

26. BMI Requirements (Check A or B.)

A. ❑ The member's BMI is greater than or equal to 30.

B. ❑ The member's BMI is greater than or equal to 27 but less than 30 with two or more of the following risk factors. Check the member's current risk factors:

- ❑ Coronary Heart Disease.
- ❑ Dyslipidemia.
- ❑ Hypertension.
- ❑ Sleep Apnea.
- ❑ Type II Diabetes Mellitus.

27. Has the member participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will the member continue to follow this treatment plan while taking an anti-obesity drug? ❑ Yes ❑ No

If yes, describe the treatment plan in the space provided.

SECTION V — AUTHORIZED SIGNATURE

28. **SIGNATURE** — Prescriber	29. Date Signed — Prescriber

SECTION VI — ADDITIONAL INFORMATION

30. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

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